ATC Healthcare Services, LLC. is an Equal Employment Opportunity employer and does not discriminate because of race, color, religion, national origin, sex, age, disability, or any other protected characteristic as established by federal, state or local laws. EOE

DATE

HEALTHCARE ASSOCIATE EMPLOYMENT APPLICATION

POSITION APPLIED FOR: **DATE AVAILABLE:**

PERSONAL

NAME (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NO. (Type just the numbers)
	PREFFERED NO.
STREET ADDRESS	ALTERNATE NO.
CITY, STATE, ZIP	CAN WE TEXT? YES NO
PLEASE LIST OTHER NAME(S) BY WHICH YOU ARE KNOWN NOW OR IN THE PAST:	E-MAIL ADDRESS
PLEASE INDICATE THE BEST TIME TO CALL YOU AND THE PHONE NUMBER YOU WOULD LIKE US TO USE:	

GENERAL

ARE YOU LEGALLY ELIGIBLE FOR EMPLOYMENT IN THE UNITED STATES? YES NO

DO YOU HAVE A RELIABLE MEANS OF TRANSPORTATION TO JOB ASSIGNMENTS? YES NO

HOW DID YOU LEARN ABOUT ATC?

WALK-IN AD (PUBLICATION): ___________________________ REFERRED BY:____________________

ATC REPRESENTATIVE NAME: ___________________________ TITLE: ___________________________

HAVE YOU EVER REGISTERED WITH OR BEEN EMPLOYED BY ATC BEFORE? YES NO

IF SO, PLEASE GIVE DATES AND ATC OFFICE:____

TO BE COMPLETED BY PATIENT CARE APPLICANTS

HAS A LICENSE/CERTIFICATION EVER BEEN ISSUED IN ANOTHER STATE? YES NO

IF YES, PLEASE GIVE DETAILS____

DO YOU HAVE A CURRENT, VALID LICENSE/CERTIFICATION? YES NO

LICENSE/CERT. TYPE____________________ STATE___________ LICENSE NO.___________ EXP. DATE___________

LICENSE/CERT. TYPE____________________ STATE___________ LICENSE NO.___________ EXP. DATE___________

SPECIALTY/OTHER____________________ STATE___________ LICENSE NO.___________ EXP. DATE___________

CPR____________________________ EXP. DATE___________ BLS____________________________ EXP. DATE___________

ACLS____________________________ EXP. DATE ___________ OTHER____________________________ EXP. DATE ___________

HAS YOUR PROFESSIONAL LICENSE, CERTIFICATE OR REGISTRATION EVER BEEN SUBJECT TO DISCIPLINARY ACTION BY ANY STATE BOARD OR BODY, SUCH AS BY REPRIMAND, SUSPENSION, REVOCATION, CONSENT ORDER, VOLUNTARY SURRENDER OR FINES? YES* NO

ARE YOU CURRENTLY WORKING UNDER A CONSENT ORDER OR WITH A RESTRICTED LICENSE FROM ANY STATE LICENSING BODY OR BOARD? YES* NO

ARE YOU AWARE OF ANY PENDING COMPLAINTS OR INVESTIGATIONS AGAINST YOUR PROFESSIONAL LICENSE, CERTIFICATE OR REGISTRATION IN ANY STATE TO THE BEST OF YOUR KNOWLEDGE? YES* NO

*IF YES, PLEASE PROVIDE DETAILS ON A SEPARATE SHEET.

DATA TO BE COMPLETED BY PATIENT CARE APPLICANTS (CONT.)

ARE YOU ABLE TO PERFORM THE ESSENTIAL FUNCTIONS OF THE POSITION FOR WHICH YOU ARE APPLYING, WITH OR WITHOUT A REASONABLE ACCOMMODATION? YES NO

DO YOU HAVE PROFESSIONAL LIABILITY INSURANCE? YES NO

IF YES, GIVE CARRIER NAME_________________________________ POLICY NUMBER_______________ EXP. DATE___________

DO YOU HAVE COMPUTER SKILLS? YES No TYPE OF SOFTWARE ____

HAVE YOU COMPLETED A COURSE IN MEDICAL BILLING/CODING? YES NO DATE__________________________

EMR EXPERIENCE? YES NO # OF YEARS: _________

WHICH EMR SOFTWARE? EPIC MCKESSON CERNER MEDITECH OTHER: __________________
(CHECK ALL THAT APPLY)

SUMMARIZE ANY SPECIAL TRAINING, SKILLS, LICENSES AND/OR CERTIFICATES THAT MAY QUALIFY YOU AS BEING ABLE TO PERFORM JOB-RELATED FUNCTIONS IN THE POSITION FOR WHICH YOU ARE APPLYING:____

____

____

____

WORK HISTORY

APPLICATIONS WILL NOT BE CONSIDERED UNLESS ALL INFORMATION IS COMPLETE, EVEN IF A RESUME IS PRESENTED.

PRESENT POSITION

FROM MONTH YEAR	TO MONTH YEAR	EMPLOYER		TELEPHONE NUMBER
		STREET ADDRESS, CITY, STATE, ZIP		
POSITION		SUPERVISOR'S EMAIL	SUPERVISOR'S NAME AND TITLE	MAY WE CONTACT? YES NO
DESCRIBE DUTIES AND SPECIALTY AREAS			REASON FOR LEAVING:	
# OF HOSPITAL BEDS (IF APPLICABLE)				

PREVIOUS POSITION

FROM MONTH YEAR	TO MONTH YEAR	EMPLOYER		TELEPHONE NUMBER
		STREET ADDRESS, CITY, STATE, ZIP		
POSITION		SUPERVISOR'S EMAIL	SUPERVISOR'S NAME AND TITLE	MAY WE CONTACT? YES NO
DESCRIBE DUTIES AND SPECIALTY AREAS			REASON FOR LEAVING:	
# OF HOSPITAL BEDS (IF APPLICABLE)				

PREVIOUS POSITION

FROM MONTH	FROM YEAR	TO MONTH	TO YEAR	EMPLOYER	TELEPHONE NUMBER
				STREET ADDRESS, CITY, STATE, ZIP	

POSITION	SUPERVISOR'S EMAIL	SUPERVISOR'S NAME AND TITLE	MAY WE CONTACT? YES NO

DESCRIBE DUTIES AND SPECIALTY AREAS	REASON FOR LEAVING:
# OF HOSPITAL BEDS (IF APPLICABLE)	

LIST OTHER EMPLOYERS AND DATES OF EMPLOYMENT. ATTACH A RESUME IF AVAILABLE.

PROFESSIONAL REFERENCES

LIST NAME AND TELEPHONE NUMBER OF THREE BUSINESS/WORK REFERENCES WHO ARE **NOT** RELATED TO YOU. IF NOT APPLICABLE, LIST THREE SCHOOL REFERENCES WHO ARE NOT RELATED TO YOU.

NAME	TELEPHONE	NUMBER OF YEARS KNOWN

EDUCATION AND TRAINING

HIGHEST GRADE COMPLETED 12 GED	COLLEGE 1 2 3 4	POST GRADUATE MASTERS PH.D	MAJOR	NO. OF YEARS COMPLETED	DEGREE OBTAINED
HIGH SCHOOL	ADDRESS				
VOCATIONAL/TECHNICAL	ADDRESS				
HOSPITAL OR NURSING SCHOOL	ADDRESS				
COLLEGE/UNIVERSITY - BA / BS	ADDRESS				
MASTERS / PH.D.	ADDRESS				

OTHER EDUCATION OR SPECIAL TRAINING (INCLUDE MILITARY):

ACKNOWLEDGMENT AND AUTHORIZATION

I represent that the information provided in this employment application (and accompanying documents, if any) is true and complete. I understand that any false information or significant omissions may disqualify me from any further consideration for employment and may be justification for dismissal from employment if discovered at a later date. I agree to immediately notify ATC Healthcare Services, LLC. if I should be convicted of any crime while my job application is pending.

I authorize investigation of all statements contained in this application and authorize any individual or entity to provide information and opinion to ATC as part of the investigation. I authorize ATC to disclose information contained in this application along with any information about me obtained through investigations or during the course of the interview process. I release ATC Healthcare services, LLC. and any individual, or entity providing information to ATC, from any legal liability for any damages from the disclosure of this information.

I understand that if accused of wrongdoing while employed, I may be subject to probe by an outside agency.

I understand and agree that, if I am hired, my employment is "at-will" which means that it is for no definite period of time and may be terminated by me or ATC at any time for any reason.

I understand that if I am hired, ATC does not guarantee any specific number of hours or shifts and I may or may not be assigned as determined by ATC. I understand and agree that I will not accept employment by any ATC client where I have been assigned by ATC for a period of six (6) months following termination of my employment with ATC.

I understand that if I am hired, a client may decide not to utilize my services at any time and will inform ATC if this occurs. That decision is made solely by the client. I understand and acknowledge that if this occurs, I may, or may not be assigned to other clients. In the event I have any concerns regarding my assignment to a client, I will immediately bring my concerns to ATC's attention.

I agree, if I am hired by ATC, to keep my credentials and JOINT COMMISSION and OSHA inservice requirements current, and to abide by the policies, procedures and supervision of the client to which I am assigned and those of ATC Healthcare Services, LLC.

Acknowledged and agreed:

____ ____________________________

Applicant Signature **Date**

(TO BE COMPLETED BY ATC REPRESENTATIVE ONLY)

On what date will employee be available for assignment?							
Hours Associate available for assignment:	7a - 3p	3p - 11p	11p – 7a	7a – 7p	7p – 7a	Other___________________	
Days available for assignment:	SAT	SUN	MON	TUE	WED	THUR	FRI
Any special requests:							

Assignment Preferences:			Comments/Area Preference:
Contracts-Local	Yes	No	
Local Travel	Yes	No	
Specialty Areas: 1st Choice	2nd Choice	3rd Choice	

ATC Date:___________________

Representative:____

REVISED 4/2019